

11931

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Grantsville, Md.</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X/Rural Grantsville, Md.</b>				d. STREET ADDRESS <b>1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>T.</b> Last <b>BITTINGER</b>				4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April, 16, 1887</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own farm</b>		11. BIRTHPLACE (State or foreign country) <b>Garrett Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elijah Bittinger</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Hare</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-36-9761</b>		17. INFORMANT Address <b>Mrs. Margaret Durst, Grantsville, Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, Generalized</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Terminal</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile - urinary and gastro-intestinal Hemorrhage</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Feb 11, 1957</b> to <b>Nov 18, 1957</b> , that I last saw the deceased alive on <b>Nov 15, 1957</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ruth Peachey M.D.</b>		ADDRESS (Street, city or town, state) <b>Grantsville, Md.</b>		DATE SIGNED <b>11/20/57</b>			
PHYSICIAN'S NAME (Type) <b>Ruth Peachey M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/21/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Grantsville</b>		22d. LOCATION (City, town, or county) (State) <b>Grantsville, Garrett Co., Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ed Newman</b>		ADDRESS <b>Grantsville, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 25 '57</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Hare</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

**BUREAU V. S.**

NOV 23 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11932

## CERTIFICATE OF DEATH

11941

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Gormaniam, W. Va.</b>		c. LENGTH OF STAY IN 16 <b>75 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X/Rural Gormaniam, W. Va.</b>		d. STREET ADDRESS <b>6 Mi. West Gormaniam</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6 Mi. West Gormaniam,</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Brown</b> Middle <b>Milison</b> Last <b>Cooper</b>		4. DATE OF DEATH Month <b>November</b> Day <b>7</b> , Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 5, 1882</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Emma Lee</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Mrs. Brown Cooper</b>		Address <b>R. D. Gormaniam, W. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cerebral hemorrhage with rt</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Left paralytic</b> DUE TO (c) <b>Hypertensive Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 days</b> <b>5 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>5 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>55</b> , to <b>Nov. 7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov. 6</b> , 19 <b>57</b> , and that death occurred at <b>6:10 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Ralph Calandrella</b> M.D. <b>Kitzmiller, Md.</b> PHYSICIAN'S NAME (Type) <b>Ralph Calandrella, M. D.</b> <b>Kitzmiller, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/10/1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>near Gormaniam, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>11/10/1957</b>		24b. REGISTRAR'S SIGNATURE <b>J. G. Rowan</b>	

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11933

## CERTIFICATE OF DEATH

11942

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GRANTSVILLE MD</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GRANTSVILLE, MD x2</b>			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LEONARD</b> Middle <b>JONAS</b> Last <b>CUSTER</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 23, 1902</b>		9. AGE (In years last birthday) <b>55 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BACK LAYER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME BUILDING</b>		11. BIRTHPLACE (State or foreign country) <b>GRANTSVILLE, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>JOHN M CUSTER</b>				14. MOTHER'S MAIDEN NAME <b>MARY BEACHY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>192-03-9922</b>		17. INFORMANT Address <b>Mrs Mable Bender, Grantsville, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Acute myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>5 years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>15 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic pulmonary fibrosis, bilateral</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY a. m. _____ p. m. _____ 19	Month _____	Day _____	Year _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>July 1, 1956</b> , to <b>Nov 7, 1957</b> , that I last saw the deceased alive on <b>Nov 5, 1957</b> , and that death occurred at <b>9:00 A.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <b>A. Paige Strong</b> M.D. <b>Salisbury, Penna Nov 7, 1957</b>				PHYSICIAN'S NAME (Type) <b>A. PAIGE STRONG MD. SALISBURY, PA.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-10-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Casselman Menonite Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Grantsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Donald J. Newman, Grantsville, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 13 57</b>		24b. REGISTRAR'S SIGNATURE <b>Decker</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF INTERMENT	
16. NAME OF FUNERAL HOME		17. NAME OF CEMETERY		18. NAME OF MINISTER	
19. NAME OF CLERGYMAN		20. NAME OF CHURCH		21. NAME OF SOCIETY	
22. NAME OF ORGANIZATION		23. NAME OF ASSOCIATION		24. NAME OF CLUB	
25. NAME OF GUILD		26. NAME OF LODGE		27. NAME OF ORDER	
28. NAME OF FRATERNITY		29. NAME OF SOCIETY		30. NAME OF CLUB	
31. NAME OF ORGANIZATION		32. NAME OF ASSOCIATION		33. NAME OF CLUB	
34. NAME OF GUILD		35. NAME OF LODGE		36. NAME OF ORDER	
37. NAME OF FRATERNITY		38. NAME OF SOCIETY		39. NAME OF CLUB	
40. NAME OF ORGANIZATION		41. NAME OF ASSOCIATION		42. NAME OF CLUB	
43. NAME OF GUILD		44. NAME OF LODGE		45. NAME OF ORDER	
46. NAME OF FRATERNITY		47. NAME OF SOCIETY		48. NAME OF CLUB	
49. NAME OF ORGANIZATION		50. NAME OF ASSOCIATION		51. NAME OF CLUB	
52. NAME OF GUILD		53. NAME OF LODGE		54. NAME OF ORDER	
55. NAME OF FRATERNITY		56. NAME OF SOCIETY		57. NAME OF CLUB	
58. NAME OF ORGANIZATION		59. NAME OF ASSOCIATION		60. NAME OF CLUB	
61. NAME OF GUILD		62. NAME OF LODGE		63. NAME OF ORDER	
64. NAME OF FRATERNITY		65. NAME OF SOCIETY		66. NAME OF CLUB	
67. NAME OF ORGANIZATION		68. NAME OF ASSOCIATION		69. NAME OF CLUB	
70. NAME OF GUILD		71. NAME OF LODGE		72. NAME OF ORDER	
73. NAME OF FRATERNITY		74. NAME OF SOCIETY		75. NAME OF CLUB	
76. NAME OF ORGANIZATION		77. NAME OF ASSOCIATION		78. NAME OF CLUB	
79. NAME OF GUILD		80. NAME OF LODGE		81. NAME OF ORDER	
82. NAME OF FRATERNITY		83. NAME OF SOCIETY		84. NAME OF CLUB	
85. NAME OF ORGANIZATION		86. NAME OF ASSOCIATION		87. NAME OF CLUB	
88. NAME OF GUILD		89. NAME OF LODGE		90. NAME OF ORDER	
91. NAME OF FRATERNITY		92. NAME OF SOCIETY		93. NAME OF CLUB	
94. NAME OF ORGANIZATION		95. NAME OF ASSOCIATION		96. NAME OF CLUB	
97. NAME OF GUILD		98. NAME OF LODGE		99. NAME OF ORDER	
100. NAME OF FRATERNITY		101. NAME OF SOCIETY		102. NAME OF CLUB	

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NOV 18 1957  
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11943

11934

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

166

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON GROVE MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>15XO.2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES KIRKWOOD DAVIES JR.</u>		4. DATE OF DEATH Month Day Year <u>NOVEMBER 9 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE -5- 1908</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAWYER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES DAVIES</u>		14. MOTHER'S MAIDEN NAME <u>EDITH SIMMONS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>578-38-0971</u>	
17. INFORMANT <u>MRS. CHARLES DAVIES</u>		Address <u>WASHINGTON GROVE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20min</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>J. Baumgartner</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Baumgartner</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11/9/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV-12-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>DARNESTOWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEAR GAITHERSBURG MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emory Golden</u>		ADDRESS <u>OAKLAND MD</u>	
24a. REC'D BY REGISTRAR <u>11/9/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. Baumgartner</u>	

261

NOV 12 1957

RECEIVED

10/10/10



11935

CERTIFICATE OF DEATH

11944 66

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			c. LENGTH OF STAY IN TB <b>14 ds.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Westernport</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Weeks Nursing Home</b>				d. STREET ADDRESS <b>r.D. 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gurnie</b> Middle <b>Lee</b> Last <b>Durst.</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>21</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 19, 1886</b>		9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William F. Durst</b>				14. MOTHER'S MAIDEN NAME <b>Mary A. Barncord</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>0</b>		17. INFORMANT <b>Mrs. Burrell Poland- Luke, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>STARVATION</b> <b>442x</b> DUE TO (b) <b>ARTERIOSCLEROTIC CARDIO-RENAL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b>DIARRHEA</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>THROMBOSIS DEGENERATIVE VASCULAR OLD STROKE</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 8</b> , 19 <b>57</b> , to <b>NOV 21st</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>NOV 20th</b> , 19 <b>57</b> , and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>58 2nd St. Oakland, Md.</b> DATE SIGNED <b>11-23-57</b>							
ACTUAL SIGNATURE <b>James H. Seaton, Jr. M.D.</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Philos Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ed Bural</b>				ADDRESS <b>Westernport, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 26 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Julia Rowan</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 26 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11936

## CERTIFICATE OF DEATH

119456

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Deer Park</b>		c. LENGTH OF STAY IN 1b <b>93 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X / Rural Deer Park,</b>		d. STREET ADDRESS <b>5 Mi. So. Deer Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5 Mi. So. Deer Park</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Susan</b> Middle <b>Elvina</b> Last <b>Harvey</b>		4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 22, 1864</b>
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Garrett Moon</b>	
14. MOTHER'S MAIDEN NAME <b>Jane Wilson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>Paul Harvey R D Deer Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerotic Heart Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>20 years</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from <b>August, 1957</b> , to <b>Nov. 17, 1957</b> , that I last saw the deceased alive on <b>November 15, 1957</b> , and that death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.		ADDRESS (Street, city or town, state) <b>77 Oak St. Oakland, Md.</b> DATE SIGNED <b>Nov. 18, 1957</b>	
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton M.D.</b>		<b>Oakland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/19/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>N.B. Harvey Family Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>5 Mi. So. Mt. Lake Park, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. C. Leighton</b>		ADDRESS <b>Oakland, Md.</b>	24a. REC'D BY REGISTRAR <b>John C. Nowan</b>
DATE <b>11/18/57</b>		24b. REGISTRAR'S SIGNATURE	



## 11937 CERTIFICATE OF DEATH

Reg. Dist. No.

11846

1. PLACE OF DEATH o. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO 21X0.2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CUPPETT NURSING HOME</b>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAUD A. HOUCK</b>				4. DATE OF DEATH Month Day Year <b>NOV. 3 1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN-23-1877</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE KEEPER</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>DAVID HOUCK</b>				14. MOTHER'S MAIDEN NAME <b>MARY ANTHONY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>W.M. O. HOUCK</b> Address <b>KINGWOOD W.VA.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 DUE TO Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerotic</b> (c) <b>Cardio-vascular Disease</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>12/12/57</b> , 19____, to <b>11/13/57</b> , 19____, that I last saw the deceased alive on <b>10/13/57</b> , 19____, and that death occurred at <b>11:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>25 ARDERT OAKLAND MD</b> DATE SIGNED <b>11/4/57</b>							
ACTUAL SIGNATURE <b>E. I. BAUMGARTNER</b> M.D.							
PHYSICIAN'S NAME (Type) <b>E. I. BAUMGARTNER</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/6/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSEHILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>OAKLAND MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b> ADDRESS <b>CUMBERLAND MD</b>				24a. REC'D BY REGISTRAR <b>11/6/57</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Julius H. Brown</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

NAME: GARRATT  
 SEX: MALE  
 RACE: WHITE  
 DATE OF BIRTH: JAN. 2, 1917  
 PLACE OF BIRTH: A. A.  
 OCCUPATION: HOUSEKEEPER  
 DECEASED: MARY ANTHONY  
 PLACE OF DEATH: W. O. HOOK KIRKWOOD W. A.  
 COUNTY: CUMBERLAND MD U. S. A.  
 REGISTERED: BOOK 1300000  
 WASHINGTON

BUREAU V. 3

NOV 12 1957

RECEIVED

CUMBERLAND MD  
 BURIAL 11/10/57  
 ROSEHILL CEMETERY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

, 11938 CERTIFICATE OF DEATH

Reg. Dist. No.

11947

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO OAKLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>176 4TH STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>KING</b> Last <b>HUGHES</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>19</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 12, 1885</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	
13. FATHER'S NAME <b>MILES KING</b>				14. MOTHER'S MAIDEN NAME <b>MARTHA CORLEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>JOSEPHINE KING OAKLAND Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Heart Disease</b> DUE TO (c) <b>Scurvy</b> <b>260X</b> DUE TO (c) <b>Scurvy</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>2 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>November 15, 1957</b> to <b>November 19, 1957</b> that I last saw the deceased alive on <b>19 Nov</b> , 19 <b>57</b> , and that death occurred at <b>3:40</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. E. Shance</b> M.D.				ADDRESS (Street, city or town, state) <b>Oakland Md</b>		DATE SIGNED <b>20 Nov 57</b>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Nov-22-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OAKLAND CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>OAKLAND Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Bolden</b>				ADDRESS <b>OAKLAND Md</b>		24a. REC'D BY REGISTRAR DATE <b>11/22/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Julia A. Rowan</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

See Page 104

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>		<p>7. PLACE OF DEATH</p>		<p>8. CAUSE OF DEATH</p>		<p>9. MANNER OF DEATH</p>		<p>10. SIGNATURE OF REGISTRAR</p>		<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>	
<p>13. NAME OF DECEASED</p>		<p>14. SEX</p>		<p>15. AGE</p>		<p>16. DATE OF BIRTH</p>		<p>17. PLACE OF BIRTH</p>		<p>18. DATE OF DEATH</p>		<p>19. PLACE OF DEATH</p>		<p>20. CAUSE OF DEATH</p>		<p>21. MANNER OF DEATH</p>		<p>22. SIGNATURE OF REGISTRAR</p>		<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF WITNESSES</p>	
<p>25. NAME OF DECEASED</p>		<p>26. SEX</p>		<p>27. AGE</p>		<p>28. DATE OF BIRTH</p>		<p>29. PLACE OF BIRTH</p>		<p>30. DATE OF DEATH</p>		<p>31. PLACE OF DEATH</p>		<p>32. CAUSE OF DEATH</p>		<p>33. MANNER OF DEATH</p>		<p>34. SIGNATURE OF REGISTRAR</p>		<p>35. SIGNATURE OF DECEASED</p>		<p>36. SIGNATURE OF WITNESSES</p>	

RECEIVED  
DEC 4 1957  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11939

## CERTIFICATE OF DEATH

11948

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accident, Md.</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>PETER</b> Middle <b>JAMES</b> Last <b>KAHL</b>				4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 30, 1871</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter-retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self-employed</b>		11. BIRTHPLACE (State or foreign country) <b>Accident, Garrett Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Valentine Kahl</b>				14. MOTHER'S MAIDEN NAME <b>Emma Hardin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Ada Kahl, Accident, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio-Renal Disease</b> DUE TO (c) <b>Diabetes</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Seizure</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-8-57</b> , 19 <b>57</b> , to <b>10-5</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>10-5</b> , 19 <b>57</b> , and that death occurred at <b>3 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James H. Feaster Jr.</b>				ADDRESS (Street, city or town, state) <b>5822 St. Oakland Rd</b>			
PHYSICIAN'S NAME (Type) <b>James H. Feaster Jr.</b>				DATE SIGNED <b>11-25-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>English Lutheran</b>		22d. LOCATION (City, town, or county) (State) <b>Accident, Garrett Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Don F. Newman</b>				ADDRESS <b>Grantsville, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 29 57</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		DEATH NO. 1000	
DATE OF DEATH 11-22-57		TIME OF DEATH 10:00 AM	
PLACE OF BIRTH BOSTON, MASS.		AGE 78	
SEX FEMALE		RACE WHITE	
OCCUPATION HOUSEWIFE		MARITAL STATUS MARRIED	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

BUREAU V. S.

NOV 29 1957

RECEIVED



11940

## CERTIFICATE OF DEATH

Reg. Dist. No. 163

1. PLACE OF DEATH o. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Westernport</b>				c. LENGTH OF STAY IN 1b <b>3 hrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4 Mi W. Westernport</b>				d. STREET ADDRESS <b>1/2 Mi. W. Westernport</b>			
3. NAME OF DECEASED (Type or print) <b>Benjamin</b> First <b>Wall</b> Middle <b>Kalbaugh</b> Last				4. DATE OF DEATH <b>Nov</b> Month <b>2</b> Day <b>1957</b> Year			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23, 1877</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shop foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad shops</b>		11. BIRTHPLACE (State or foreign country) <b>Westernport, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jack Kalbaugh</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Simmons</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>705-12-4703</b>		17. INFORMANT Address <b>Harry Kalbaugh-Westernport, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerosis and Hypertension</b> DUE TO (c) <b>Prostatic Hypertrophy</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 Minutes</b> <b>5 Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>May 10, 1952</b> , to <b>Nov. 2, 1957</b> , that I last saw the deceased alive on <b>Oct. 28, 1957</b> , and that death occurred at <b>1140 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Paul R. Wilson</b>		M.D. <b>Piedmont, N.C.</b>		DATE SIGNED <b>Nov 4, 1957</b>			
PHYSICIAN'S NAME (Type) <b>Paul R. Wilson, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 5, 57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Philos Cem.</b>	22d. LOCATION (City, town, or county) <b>Westernport,</b>	(State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Bual</b>		ADDRESS <b>Westernport, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>11-5-57</b>	24b. REGISTRAR'S SIGNATURE <b>Doray Patterson</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]		7. MARITAL STATUS [REDACTED]		8. COLOR [REDACTED]	
9. CAUSE OF DEATH [REDACTED]		10. PLACE OF DEATH [REDACTED]		11. DATE OF DEATH [REDACTED]		12. TIME OF DEATH [REDACTED]	
13. SIGNATURE OF PHYSICIAN [REDACTED]		14. SIGNATURE OF REGISTRAR [REDACTED]		15. SIGNATURE OF WITNESS [REDACTED]		16. SIGNATURE OF DECEASED [REDACTED]	

BUREAU V. 3

NOV 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11941

CERTIFICATE OF DEATH

11950

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>	
c. LENGTH OF STAY IN 1b <b>60 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Weeks Nursing Home</b>		d. STREET ADDRESS <b>Dennett Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elizab</b> eth Middle <b>Hannah</b> Last <b>Kloepfel</b>		4. DATE OF DEATH Month <b>November</b> Day <b>14</b> , Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 20, 1877</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Neerbe Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Miller</b>		14. MOTHER'S MAIDEN NAME <b>Mary Slabau gh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>----</b>	
17. INFORMANT <b>Helen Lough</b>		Address <b>Mt. Lake Pa rk, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Starvation</b> <b>571.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DIARRHEA, C.U.</b> DUE TO (c) <b>Sex. i. ty</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1957</b> , to <b>Nov 14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov 13</b> , 19 <b>57</b> , and that death occurred at <b>5:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b>		ADDRESS (Street, city or town, state) <b>58 2nd St. Oakland, Md.</b>	
DATE SIGNED <b>11-16-57</b>			
PHYSICIAN'S NAME (Type) <b>James H., Feaster, Jr. M.D.</b>		<b>Oakland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/16/1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Gnegy Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>11 Mi. So. Oakland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. C. Leighton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 11/16/57</b>		24b. REGISTRAR'S SIGNATURE <b>Julia G. Bowman</b>	

BUREAU V. S.

DEC 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11942

## CERTIFICATE OF DEATH

Reg. Dist. No.

11951  
11661

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>LEE</b> Last <b>LEE</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>9</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCTOBER 5, 1880</b>	
9. AGE (In years last birthday) <b>77 yrs.</b>		IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>		IF UNDER 24 HRS. Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>GENERAL</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>DAVID LEE</b>				14. MOTHER'S MAIDEN NAME <b>ELIZA LEE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>UNKNOWN</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>JOSEPH LEE (SELF)</b>				Address <b>BOX 135, R. 1, OAKLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA LOBAR, C.V.</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIO-SCLEROTIC Cardio-Pericardial</b> DUE TO <b>DISEASE</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>DEC 11-8, 1957</b> to <b>11-8, 1957</b> that I last saw the deceased alive on <b>NOVEMBER 8, 1957</b> and that death occurred at <b>4:05 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>OAKLAND, MD.</b> DATE SIGNED <b>11/9/57</b> ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b> M.D. <b>OAKLAND, MD.</b> PHYSICIAN'S NAME (Type) <b>JAMES H. FEASTER, JR., M.D.</b> <b>OAKLAND, MARYLAND</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>NOV-11-1957</b> 22c. NAME OF CEMETERY OR CREMATORY <b>OAK GROVE CEMETERY</b> 22d. LOCATION (City, town, or county) (State) <b>NEAR GORMAN MD</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Bolden</b> ADDRESS <b>OAKLAND MD</b> 24a. REG'D BY REGISTRAR DATE <b>11/10/57</b> 24b. REGISTRAR'S SIGNATURE <b>Julius G. Rowen</b> <b>J.R.</b>							



11

BUREAU V. S.

NOV 12 1957

RECEIVED

*[Handwritten signature]*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11943 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11952  
106

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL GORMANIA</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL GORMANIA. XI</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARSHALL TALMAGE LEWIS</b>				4. DATE OF DEATH Month Day Year <b>Nov. 18 1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov.-19, 1898</b>	9. AGE (In years last birthday) <b>59 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GARRETT MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EMORY LEWIS</b>				14. MOTHER'S MAIDEN NAME <b>STELLA KING</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>232-09-5396</b>		17. INFORMANT Address <b>MRS. BIRTHA LEWIS GORMANIA W. VA.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion (left)</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Congestion &amp; Edema</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Fairview MD</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>E. I. Baumgartner MD</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>E. I. BAUMGARTNER MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Nov-21-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FAIRVIEW</b>		22d. LOCATION (City, town, or county) (State) <b>FAIRVIEW MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wayne C. Spigle</b>				ADDRESS <b>DAVIS W. VA</b>		24a. REC'D BY REGISTRAR <b>12/1/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>James H. Brown JR</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

WESTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, date, time, place, and cause of death. The form is partially filled out with handwritten text.

**RECEIVED**  
**BUREAU V. S.**  
DEC 4 1957

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**11953**

**11944**

**CERTIFICATE OF DEATH**

Reg. Dist. No. **166**

1. PLACE OF DEATH o. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland.</b>				c. LENGTH OF STAY IN 1b <b>80 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Alder St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Asa</b> Middle <b>Totten</b> Last <b>Matthews</b>				4. DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 13, 1875</b>	
9. AGE (In years last birthday) yrs. <b>82</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Private Practice</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Simon Matthews</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Totten</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>214-32-3239</b>		17. INFORMANT <b>Mrs. Frances Matthews</b>		Address <b>Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema, Acute</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of the lung Metastatic unknown</b> DUE TO (c) <b>Carcinoma of Stomach, Infiltrative unknown</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>57</b> , to <b>Nov. 2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov. 2</b> , 19 <b>57</b> , and that death occurred at <b>2:30 P.</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.				ADDRESS (Street, city or town, State) <b>77 Oak St., Oakland, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M.D.</b>				DATE SIGNED <b>Nov. 4, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/5/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oakland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Leighton</b>				ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>Julia L. Gowan</b>	
				DATE <b>11/4/57</b>			

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NOV 12 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11945

## CERTIFICATE OF DEATH

11954

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>West Virginia</b> b. COUNTY <b>Grant</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cuppert Nursing Home</b>		d. STREET ADDRESS <b>85 x - 3</b>	
3. NAME OF DECEASED (Type or print) First <b>LAURA</b> Middle <b>BLANCHE</b> Last <b>MAY</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>22</b> , Year <b>1957</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 10, 1867</b>
9. AGE (In years last birthday) yrs. <b>90</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE KEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOSIAH MAY</b>		14. MOTHER'S MAIDEN NAME <b>HANNAH STOUTER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>ARTHUR S. MAY</b>		Address <b>BAYARD, W. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO (b) <b>Atherosclerotic Cardio Vascular Disease 15 yrs.</b> DUE TO (c) <b>1 day</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 10, 1957</b> to <b>Nov. 22, 1957</b> , that I last saw the deceased alive on <b>Nov. 19, 1957</b> , and that death occurred at <b>12:45 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.		ADDRESS (Street, city or town, state) <b>77 Oak St. Oakland 22 Md.</b>	
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M. D.</b>		Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/25/1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>CUMBERLAND, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas. F. Sharpless</b>		ADDRESS <b>BLAINE, W. Va.</b>	
24a. REC'D BY REGISTRAR <b>DATE 11/23/57</b>		24b. REGISTRAR'S SIGNATURE <b>Julia C. Taylor</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11946

## CERTIFICATE OF DEATH

Reg. Dist. No.

11955

1. PLACE OF DEATH o. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>PRESTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. LENGTH OF STAY IN 1b <b>ONE WEEK</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>85 X-3</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ALLETTA</b> Middle <b>MAYER</b> Last <b>MAYER</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>30</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1873</b> <b>APRIL 25, 1873</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>4</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House keeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
13. FATHER'S NAME <b>ALLEN FORMAN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN Caroline Forquer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>LEWIS R. JONES, FIRST NAT'L BANK BLD'G, OAKLAND MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerotic Cond. - Renal disease</b> YEARS DUE TO (c) <b>Obesity</b> YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Nov 29</b> , 19 <b>57</b> , to <b>Nov 29</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov 29</b> , 19 <b>57</b> , and that death occurred at <b>5:50 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>58 West Oakland Md</b> DATE SIGNED <b>11-30-57</b>							
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b>				M.D. <b>58 West Oakland Md</b>			
PHYSICIAN'S NAME (Type) <b>JAMES H. FEASTER, M.D.</b>				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/3/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Terra Alta Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Terra Alta, W. Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>				ADDRESS <b>Oakland, Md.</b>		24a. RECD BY REGISTRAR DATE <b>12/2/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Julia Bowen</b>			

RECEIVED

DEC 4 1957

BUREAU V. S.

1. NAME OF DECEASED JAMES EARL RAY		2. SEX MALE		3. AGE 35		4. DATE OF DEATH JUN 6 1957		5. PLACE OF DEATH MEMPHIS, TENN.	
6. OCCUPATION ATTORNEY		7. MARITAL STATUS SINGLE		8. COLOR WHITE		9. HEIGHT 5' 10"		10. WEIGHT 175	
11. BIRTH DATE JUN 10 1922		12. BIRTH PLACE ALABAMA		13. EDUCATION HIGH SCHOOL		14. RELIGION METHODIST		15. SOCIAL SECURITY NO. [REDACTED]	
16. MOTHER'S NAME [REDACTED]		17. FATHER'S NAME [REDACTED]		18. MOTHER'S BIRTH DATE [REDACTED]		19. FATHER'S BIRTH DATE [REDACTED]		20. MOTHER'S BIRTH PLACE [REDACTED]	
21. FATHER'S BIRTH PLACE [REDACTED]		22. DECEASED'S BIRTH DATE JUN 10 1922		23. DECEASED'S BIRTH PLACE ALABAMA		24. DECEASED'S OCCUPATION ATTORNEY		25. DECEASED'S MARITAL STATUS SINGLE	
26. DECEASED'S COLOR WHITE		27. DECEASED'S HEIGHT 5' 10"		28. DECEASED'S WEIGHT 175		29. DECEASED'S RELIGION METHODIST		30. DECEASED'S SOCIAL SECURITY NO. [REDACTED]	
31. DECEASED'S MOTHER'S NAME [REDACTED]		32. DECEASED'S FATHER'S NAME [REDACTED]		33. DECEASED'S MOTHER'S BIRTH DATE [REDACTED]		34. DECEASED'S FATHER'S BIRTH DATE [REDACTED]		35. DECEASED'S MOTHER'S BIRTH PLACE [REDACTED]	
36. DECEASED'S FATHER'S BIRTH PLACE [REDACTED]		37. DECEASED'S BIRTH DATE JUN 10 1922		38. DECEASED'S BIRTH PLACE ALABAMA		39. DECEASED'S OCCUPATION ATTORNEY		40. DECEASED'S MARITAL STATUS SINGLE	
41. DECEASED'S COLOR WHITE		42. DECEASED'S HEIGHT 5' 10"		43. DECEASED'S WEIGHT 175		44. DECEASED'S RELIGION METHODIST		45. DECEASED'S SOCIAL SECURITY NO. [REDACTED]	
46. DECEASED'S MOTHER'S NAME [REDACTED]		47. DECEASED'S FATHER'S NAME [REDACTED]		48. DECEASED'S MOTHER'S BIRTH DATE [REDACTED]		49. DECEASED'S FATHER'S BIRTH DATE [REDACTED]		50. DECEASED'S MOTHER'S BIRTH PLACE [REDACTED]	
51. DECEASED'S FATHER'S BIRTH PLACE [REDACTED]		52. DECEASED'S BIRTH DATE JUN 10 1922		53. DECEASED'S BIRTH PLACE ALABAMA		54. DECEASED'S OCCUPATION ATTORNEY		55. DECEASED'S MARITAL STATUS SINGLE	
56. DECEASED'S COLOR WHITE		57. DECEASED'S HEIGHT 5' 10"		58. DECEASED'S WEIGHT 175		59. DECEASED'S RELIGION METHODIST		60. DECEASED'S SOCIAL SECURITY NO. [REDACTED]	
61. DECEASED'S MOTHER'S NAME [REDACTED]		62. DECEASED'S FATHER'S NAME [REDACTED]		63. DECEASED'S MOTHER'S BIRTH DATE [REDACTED]		64. DECEASED'S FATHER'S BIRTH DATE [REDACTED]		65. DECEASED'S MOTHER'S BIRTH PLACE [REDACTED]	
66. DECEASED'S FATHER'S BIRTH PLACE [REDACTED]		67. DECEASED'S BIRTH DATE JUN 10 1922		68. DECEASED'S BIRTH PLACE ALABAMA		69. DECEASED'S OCCUPATION ATTORNEY		70. DECEASED'S MARITAL STATUS SINGLE	
71. DECEASED'S COLOR WHITE		72. DECEASED'S HEIGHT 5' 10"		73. DECEASED'S WEIGHT 175		74. DECEASED'S RELIGION METHODIST		75. DECEASED'S SOCIAL SECURITY NO. [REDACTED]	
76. DECEASED'S MOTHER'S NAME [REDACTED]		77. DECEASED'S FATHER'S NAME [REDACTED]		78. DECEASED'S MOTHER'S BIRTH DATE [REDACTED]		79. DECEASED'S FATHER'S BIRTH DATE [REDACTED]		80. DECEASED'S MOTHER'S BIRTH PLACE [REDACTED]	
81. DECEASED'S FATHER'S BIRTH PLACE [REDACTED]		82. DECEASED'S BIRTH DATE JUN 10 1922		83. DECEASED'S BIRTH PLACE ALABAMA		84. DECEASED'S OCCUPATION ATTORNEY		85. DECEASED'S MARITAL STATUS SINGLE	
86. DECEASED'S COLOR WHITE		87. DECEASED'S HEIGHT 5' 10"		88. DECEASED'S WEIGHT 175		89. DECEASED'S RELIGION METHODIST		90. DECEASED'S SOCIAL SECURITY NO. [REDACTED]	
91. DECEASED'S MOTHER'S NAME [REDACTED]		92. DECEASED'S FATHER'S NAME [REDACTED]		93. DECEASED'S MOTHER'S BIRTH DATE [REDACTED]		94. DECEASED'S FATHER'S BIRTH DATE [REDACTED]		95. DECEASED'S MOTHER'S BIRTH PLACE [REDACTED]	
96. DECEASED'S FATHER'S BIRTH PLACE [REDACTED]		97. DECEASED'S BIRTH DATE JUN 10 1922		98. DECEASED'S BIRTH PLACE ALABAMA		99. DECEASED'S OCCUPATION ATTORNEY		100. DECEASED'S MARITAL STATUS SINGLE	
101. DECEASED'S COLOR WHITE		102. DECEASED'S HEIGHT 5' 10"		103. DECEASED'S WEIGHT 175		104. DECEASED'S RELIGION METHODIST		105. DECEASED'S SOCIAL SECURITY NO. [REDACTED]	
106. DECEASED'S MOTHER'S NAME [REDACTED]		107. DECEASED'S FATHER'S NAME [REDACTED]		108. DECEASED'S MOTHER'S BIRTH DATE [REDACTED]		109. DECEASED'S FATHER'S BIRTH DATE [REDACTED]		110. DECEASED'S MOTHER'S BIRTH PLACE [REDACTED]	
111. DECEASED'S FATHER'S BIRTH PLACE [REDACTED]		112. DECEASED'S BIRTH DATE JUN 10 1922		113. DECEASED'S BIRTH PLACE ALABAMA		114. DECEASED'S OCCUPATION ATTORNEY		115. DECEASED'S MARITAL STATUS SINGLE	
116. DECEASED'S COLOR WHITE		117. DECEASED'S HEIGHT 5' 10"		118. DECEASED'S WEIGHT 175		119. DECEASED'S RELIGION METHODIST		120. DECEASED'S SOCIAL SECURITY NO. [REDACTED]	
121. DECEASED'S MOTHER'S NAME [REDACTED]		122. DECEASED'S FATHER'S NAME [REDACTED]		123. DECEASED'S MOTHER'S BIRTH DATE [REDACTED]		124. DECEASED'S FATHER'S BIRTH DATE [REDACTED]		125. DECEASED'S MOTHER'S BIRTH PLACE [REDACTED]	
126. DECEASED'S FATHER'S BIRTH PLACE [REDACTED]		127. DECEASED'S BIRTH DATE JUN 10 1922		128. DECEASED'S BIRTH PLACE ALABAMA		129. DECEASED'S OCCUPATION ATTORNEY		130. DECEASED'S MARITAL STATUS SINGLE	
131. DECEASED'S COLOR WHITE		132. DECEASED'S HEIGHT 5' 10"		133. DECEASED'S WEIGHT 175		134. DECEASED'S RELIGION METHODIST		135. DECEASED'S SOCIAL SECURITY NO. [REDACTED]	
136. DECEASED'S MOTHER'S NAME [REDACTED]		137. DECEASED'S FATHER'S NAME [REDACTED]		138. DECEASED'S MOTHER'S BIRTH DATE [REDACTED]		139. DECEASED'S FATHER'S BIRTH DATE [REDACTED]		140. DECEASED'S MOTHER'S BIRTH PLACE [REDACTED]	
141. DECEASED'S FATHER'S BIRTH PLACE [REDACTED]		142. DECEASED'S BIRTH DATE JUN 10 1922		143. DECEASED'S BIRTH PLACE ALABAMA		144. DECEASED'S OCCUPATION ATTORNEY		145. DECEASED'S MARITAL STATUS SINGLE	
146. DECEASED'S COLOR WHITE		147. DECEASED'S HEIGHT 5' 10"		148. DECEASED'S WEIGHT 175		149. DECEASED'S RELIGION METHODIST		150. DECEASED'S SOCIAL SECURITY NO. [REDACTED]	
151. DECEASED'S MOTHER'S NAME [REDACTED]		152. DECEASED'S FATHER'S NAME [REDACTED]		153. DECEASED'S MOTHER'S BIRTH DATE [REDACTED]		154. DECEASED'S FATHER'S BIRTH DATE [REDACTED]		155. DECEASED'S MOTHER'S BIRTH PLACE [REDACTED]	
156. DECEASED'S FATHER'S BIRTH PLACE [REDACTED]		157. DECEASED'S BIRTH DATE JUN 10 1922		158. DECEASED'S BIRTH PLACE ALABAMA		159. DECEASED'S OCCUPATION ATTORNEY		160. DECEASED'S MARITAL STATUS SINGLE	
161. DECEASED'S COLOR WHITE		162. DECEASED'S HEIGHT 5' 10"		163. DECEASED'S WEIGHT 175		164. DECEASED'S RELIGION METHODIST		165. DECEASED'S SOCIAL SECURITY NO. [REDACTED]	
166. DECEASED'S MOTHER'S NAME [REDACTED]		167. DECEASED'S FATHER'S NAME [REDACTED]		168. DECEASED'S MOTHER'S BIRTH DATE [REDACTED]		169. DECEASED'S FATHER'S BIRTH DATE [REDACTED]		170. DECEASED'S MOTHER'S BIRTH PLACE [REDACTED]	
171. DECEASED'S FATHER'S BIRTH PLACE [REDACTED]		172. DECEASED'S BIRTH DATE JUN 10 1922		173. DECEASED'S BIRTH PLACE ALABAMA		174. DECEASED'S OCCUPATION ATTORNEY		175. DECEASED'S MARITAL STATUS SINGLE	
176. DECEASED'S COLOR WHITE		177. DECEASED'S HEIGHT 5' 10"		178. DECEASED'S WEIGHT 175		179. DECEASED'S RELIGION METHODIST		180. DECEASED'S SOCIAL SECURITY NO. [REDACTED]	
181. DECEASED'S MOTHER'S NAME [REDACTED]		182. DECEASED'S FATHER'S NAME [REDACTED]		183. DECEASED'S MOTHER'S BIRTH DATE [REDACTED]		184. DECEASED'S FATHER'S BIRTH DATE [REDACTED]		185. DECEASED'S MOTHER'S BIRTH PLACE [REDACTED]	
186. DECEASED'S FATHER'S BIRTH PLACE [REDACTED]		187. DECEASED'S BIRTH DATE JUN 10 1922		188. DECEASED'S BIRTH PLACE ALABAMA		189. DECEASED'S OCCUPATION ATTORNEY		190. DECEASED'S MARITAL STATUS SINGLE	
191. DECEASED'S COLOR WHITE		192. DECEASED'S HEIGHT 5' 10"		193. DECEASED'S WEIGHT 175		194. DECEASED'S RELIGION METHODIST		195. DECEASED'S SOCIAL SECURITY NO. [REDACTED]	
196. DECEASED'S MOTHER'S NAME [REDACTED]		197. DECEASED'S FATHER'S NAME [REDACTED]		198. DECEASED'S MOTHER'S BIRTH DATE [REDACTED]		199. DECEASED'S FATHER'S BIRTH DATE [REDACTED]		200. DECEASED'S MOTHER'S BIRTH PLACE [REDACTED]	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 11947 Item 9 Film 0223 12-12-57 et 11956 11956 Reg. Dist. No. 166 11947 Item 9 Film 0223 12-12-57 et CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>West Virginia</b> b. COUNTY <b>Preston</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Terra Alta</b>	
c. LENGTH OF STAY IN 1b <b>17 days</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>		d. STREET ADDRESS <b>Route No. 1, Lime Plant Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Thaddeus</b> Middle <b>Ellsworth</b> Last <b>Meese</b>		4. DATE OF DEATH Month <b>November</b> Day <b>11</b> , Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1886</b>
9. AGE (In years last birthday) <b>71 1/4</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>14</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>McHenry, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph B. Meese</b>		14. MOTHER'S MAIDEN NAME <b>Mary Welsh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>H. Wade Meese, Oakland, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> <b>420.1</b> DUE TO <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Insufficiency</b> DUE TO (c) <b>Arteriosclerosis and Senility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> <b>16 days</b> <b>2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 4</b> , 19 <b>55</b> , to <b>Nov. 11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov. 11</b> , 19 <b>57</b> , and that death occurred at <b>4:45 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles E. Smith</b>		DATE SIGNED <b>November 12, 1957</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES E. SMITH</b>		ADDRESS (Street, city or town, state) <b>Terra Alta, W.Va.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 14, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Thayersville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Thayersville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.R. Watson</b>		ADDRESS <b>Terra Alta, W.Va.</b>	
24a. REC'D BY REGISTRAR <b>11/14/57</b>		24b. REGISTRAR'S SIGNATURE <b>Julius C. Brown JR</b>	



BUREAU V. 8

1057 7 050

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11948 Item 8 Film G223 12-16-57 et

### CERTIFICATE OF DEATH

Reg. Dist. No.

11957  
766

1. PLACE OF DEATH o. COUNTY <b>GARRETT CO. MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SWANTON MO.</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>EARL</b> Last <b>RECKNER</b>				4. DATE OF DEATH Month <b>NOV.</b> Day <b>27</b> Year <b>1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1893</b> <b>JAN.-19-1893</b>	9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>MERCHANT.</b>		11. BIRTHPLACE (State or foreign country) <b>BITTINGER MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>AMOS RECKNER</b>				14. MOTHER'S MAIDEN NAME <b>ANNA BUCKEL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WORLD WAR #1</b> <b>213-05-2731</b>		17. INFORMANT <b>MRS. FRED A. RECKNER</b> Address <b>SWANTON MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Heart Disease</b> DUE TO <b>Chronic failing Hypertrophy</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b> <b>4 years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/18/</b> , <b>1955</b> to <b>11/27/</b> , <b>1957</b> , that I last saw the deceased alive on <b>26 Nov</b> , <b>1957</b> , and that death occurred at <b>1:30 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A.E. Mance</b> M.D.				ADDRESS (Street, city or town, state) <b>Oakland Md</b> DATE SIGNED <b>27 Nov 57</b>			
PHYSICIAN'S NAME (Type) <b>A.E. MANCE, M.D.</b>				101 #HIRD ST., OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV.-29-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>NEAR SWANTON MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Bolden</b>				ADDRESS <b>OAKLAND MD.</b>		24a. REC'D BY REGISTRAR <b>11/29/57</b> 24b. REGISTRAR'S SIGNATURE <b>Julia P. Brown</b>	

HAWKLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
 CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN J. SMITH"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		RACE [Faint text, possibly "White"]	
DATE OF DEATH [Faint text, possibly "Dec 10, 1957"]		PLACE OF DEATH [Faint text, possibly "Home"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
DISEASE OR INJURY [Faint text, possibly "Myocardial Infarction"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
CITY [Faint text, possibly "Baltimore"]		COUNTY [Faint text, possibly "Baltimore"]	
STATE [Faint text, possibly "Maryland"]		ZIP CODE [Faint text, possibly "21201"]	

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 BUREAU V. 5

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11949

## CERTIFICATE OF DEATH

## 11958

Reg. Dist. No. 162

<b>1. PLACE OF DEATH</b> o. COUNTY <u>Garrett</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Garrett</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland, Md.</u>			c. LENGTH OF STAY IN 1b <u>25 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accident, Md. x2</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Weeks Nursing Home, Oakland, Md.</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>EMMA</u> Middle <u>KAHL</u> Last <u>RICHTER</u>				<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1880</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>		IF UNDER 24 HRS. Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Accident, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Ludwig Kahl</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Walter Richter, Accident, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>77</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2nd stroke Left H.P. Sept. 24th 1957</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 mins.</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1957</u> Hour <u>19</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>58 2nd St. Oakland, Md.</u>	
20f. (City or town) <u>Accident, Md.</u>				20g. (County) <u>Garrett</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>6-29-57</u> to <u>10-29-57</u> , that I last saw the deceased alive on <u>10-29-57</u> , and that death occurred at <u>8:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>58 2nd St. Oakland, Md.</u> DATE SIGNED <u>11-6-57</u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>58 2nd St. Oakland, Md.</u>							
PHYSICIAN'S NAME (Type) <u>J. H. Feaster, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Accident, Garrett Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Grantsville, Md.</u>		24a. REC'D BY REGISTRAR <u>11/6/57</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				DATE <u>11/6/57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

111

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. S.

NOV 12 1957

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11/12/57



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11950

## CERTIFICATE OF DEATH

Reg. Dist. No.

11959  
766

1. PLACE OF DEATH o. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL OAKLAND</b>		c. LENGTH OF STAY IN 1b <b>7 YEARS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GARRY</b> Middle <b>LEE</b> Last <b>RIDDER</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>22</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY-13-1869</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GARRETT Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN RIDDER</b>		14. MOTHER'S MAIDEN NAME <b>KATHRYN WILT.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>DAVID RIDDER</b>		Address <b>OAKLAND, MD. RT.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>434.3 Sudden &amp; Heart Disease</b> DUE TO <b>Heart Disease.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 21st</b> , 19 <b>57</b> , to <b>Nov. 22nd</b> , 19 <b>57</b> at I last saw the deceased alive on <b>19</b> , and that death occurred at <b>4:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. W. Wenzel</b> M.D.		ADDRESS (Street, city or town, state) <b>Oak &amp; English St.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>J OHN Wm WENZEL</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>NOV-24-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>RED HOUSE CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>RED HOUSE, NEAR OAKLAND, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Golden</b>		ADDRESS <b>OAKLAND, MD.</b>	24a. REC'D BY REGISTRAR <b>11/24/57</b> 24b. REGISTRAR'S SIGNATURE <b>Julia Howard</b>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

1  
11951 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11969  
Reg. Dist. No. 766

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN lb 10 1/2 HOURS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SWANTON	
3. NAME OF DECEASED (Type or print) First FRED A Middle CREOLA Last SWEITZER		4. DATE OF DEATH Month NOVEMBER Day 13, Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 28, 1919
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR RHODES		14. MOTHER'S MAIDEN NAME ROSE BUCKALEW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN		16. SOCIAL SECURITY NO. ————	
17. INFORMANT Address HOWARD SWEITZER, SWANTON, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 11 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. I. Baumgartner		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) E. I. BAUMGARTNER, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED NOVEMBER 13, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/15/1957	
22c. NAME OF CEMETERY OR CREMATORY George Cemetery		22d. LOCATION (City, town, or county) (State) Near Swanton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE 11/13/57	
24b. REGISTRAR'S SIGNATURE Julia A. Rowan			

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is mostly blank with some faint markings.

RECEIVED  
DEC 4 1957  
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11952

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11961  
11/66

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. LAKE PARK</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. STREET ADDRESS <b>MT. LAKE PARK.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RUBY KATHRYN TURNEY</b>				4. DATE OF DEATH Month <b>NOV.</b> Day <b>22</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. - 17 - 1901</b>	
9. AGE (In years last birthday) <b>56 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CLEVELAND OHIO</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>FRANCIS VAN TYNE.</b>				14. MOTHER'S MAIDEN NAME <b>WINIFRED WARNER.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>HARRY TURNEY</b> Address <b>MT. LAKE PARK, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>E. J. Baumbach</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>E. J. Baumbach</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV. - 25 - 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OAKLAND CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>OAKLAND MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Bolden</b>				ADDRESS <b>OAKLAND MD.</b>		24a. REC'D BY REGISTRAR <b>11/25/57</b>	
						24b. REGISTRAR'S SIGNATURE <b>Julius A. Howard Jr</b>	



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

COUNTY OF MARYLAND CITY OF BALTIMORE		DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS	
NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]	
MARITAL STATUS [Faint text]		CAUSE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
SIGNATURE OF EXAMINER [Faint text]		SIGNATURE OF WITNESS [Faint text]	
DATE OF EXAMINATION [Faint text]		TIME OF EXAMINATION [Faint text]	

RECEIVED  
 DEC 4 1957  
 BUREAU V. S.